Massachusetts Division of Health Care Finance and Policy
2 Boylston Street, Boston, MA 02116
Tel: 617-988-3100 Fax: 617-727-7662 TTY: 617-988-3175
DHCFP Help Desk (800) 609-7232

Exhibit 1

CONTINUOUS SKILLED NURSING EXPENSE REPORT

AGENCY NAME _____ CONTACT NAME _____

STREET _____ CONTACT TITLE _____

CITY, STATE, ZIP _____ CONTACT PHONE # _____

DMA PROVIDER # _____ CONTACT FAX # _____

CONTACT EMAIL ADDRESS _____

FOR THE PERIOD OF January 1, 2007 - December 31, 2007

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Procedure Code	Rates/ 15min *	Hourly Rate	Total Hours Billed	Total MassHlth Pymt	Total Hours Worked	Total Salary Paid	Taxes FICA %	Taxes Other %	Fringe Benefits %	Travel %	Other** %	Total Compensation	Minimum Compensation	Pass (Fail) Variance
T1002	$8.37	$33.48												
T1002 UJ	$9.04	$36.16												
T1002	$12.56	$50.24												
T1003	$6.68	$26.72												
T1003 UJ	$7.21	$28.84												
T1003	$10.02	$40.08												
T1002 TT	$12.56	$50.24												
T1002 U1	$13.57	$54.28												
T1002 TT	$18.85	$75.40												
T1003 TT	$10.02	$40.08												
T1003 U1	$10.82	$43.28												
T1003 TT	$15.03	$60.12												
T1002 U2	$14.65	$58.60												
T1002 U3	$15.83	$63.32												
T1002 U2	$21.98	$87.92												
T1003 U2	$11.69	$46.76												
T1003 U3	$12.62	$50.48												
T1003 U2	$17.54	$70.16												
AGENCY TOTAL														

*Rates are effective for calendar year 2007, as published in Administrative Bulletin 07-04.

* *Please specify _____ (See Instructions)

The agency representative, whose signature appears below, is acknowledging to the best of his/her knowledge, by said signature, that the information in this report is true, accurate, and prepared with applicable regulations and instructions.

_____ _____

Signature of Agency Representative Date

_____ _____

Print Name of Signatory (above) Print Title